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LAW CONTROLLING PANDEMICS IN INDIA: PAST, PRESENT AND FUTURE

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India has been one of the worst-hit nations by a pandemic named COVID-19 and has suffered the major wrath of the pandemic. Pandemics across the world have been ignored and have not been well integrated into mainstream political history, into wider interregional and transnational histories of disease, or reframed in the context of concerns about the nature and meaning of globalization. World at large has recently witnessed and is in fact, witnessing that how a pandemic could wreak havoc and impinge upon nations' growth. The pandemics have the ability to transport the world to extraordinary times where even the so-called robust economies could crumble and fall apart. Talking about the world's largest democracy i.e., India, it has had its own tryst with pandemics. A pandemic has a colossal impact on human lives and touches upon every aspect of human life and India has been no exception to it. India was last hit by an epidemic titled bubonic plague, in 1890s, which led to passing of the Epidemic Diseases Act, 1897. Ever since then, the Epidemic Diseases Act, 1897 has held the field. With the bitter experience of COVID-19, there is a need to have a new, firm and stringent law dealing solely with epidemics given the fact that the extant Epidemic Diseases Act, 1897 is a century-old legislation and was passed in haste (drafted and passed in less than a week) when India was massively hit by bubonic plague in September, 1896. Again in 2020, India has met with another pandemic named COVID-19, which has its genesis in China. In order to control a pandemic named COVID-19, India is currently placing heavy reliance on the Disaster Management Act, 2005 which is a law majorly dealing with natural calamities. This research paper sets out evolvement of law from times of bubonic plague that had hit India in 1896 to Spanish flu in 1918 and then to COVID-19. The paper subsequently analyzes if the law dealing with epidemics evolved in these one hundred and twenty five years or

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it has remained static.

The exact purport of the terms 'epidemic' and 'pandemic'.

The World Health Organization defines epidemics as "the occurrence in a community or region of cases of an illness, specific health-related behaviour, or other health-related events clearly in excess of normal expectancy."[2] Epidemics are characterised by the rapid spread of the specific disease across a large number of people within a short period of time.

As per the World Health Organization, pandemic is the worldwide spread of a new disease[3]. A dictionary of Epidemiology defines a pandemic as an epidemic occurring worldwide, or over a very wide area, crossing international boundaries and usually affecting a large number of people.

While in layman language, people use the terms "epidemic" and "pandemic" interchangeably, however, if one goes deep into the meanings of the same, it would be noticed that there is a difference in the meanings of the two terms. An epidemic becomes a pandemic when it spreads over significant geographical areas and affects a large percent of the population. Pandemic, therefore, is an epidemic which occurs across the globe or large portion of the world population gets affected by it.

Plague leading to enactment of law on epidemic diseases.

Bubonic plague was one of the major crisis in the history of colonial India. Bubonic plague originated in Yunnan, China, which was caused by the bite of infected fleas in rodents or contact with the carcass of an infected rodent in humans. The plague arrived in British India from Hong Kong through trading ships. The first official case of bubonic plague was reported in Mandvi district in Bombay Presidency, on September 23, 1896[4].

The plague reached its peak in 1907 when 1.3 million casualties were reported across India and thereafter, the plague started subsiding[5]. The bubonic plague had

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2) Available at https://www.who.int/hac/about/definitions/en/#:~:text=Checchi%20and%20Roberts).-,Epidemic,cases%20occur%20 are%20specified%20hprecisely. as last accessed on October 23, 2020.

3) Available at https://www.who.int/csr/disease/swineflu/frequently_asked_questions/pandemic/en/ as last accessed on October 24, 2020.

4) J. Samal, *A historical exploration of pandemics of some selected diseases in the world*, International Journal of Health Sciences & Research 2014, Issue 4(2), pp.165-169.

5) Rakesh PS, *The Epidemic Diseases Act of 1897: Public health relevance in the current scenario*, Indian Journal of Medical Ethics, Jul-Sep 2016, pp.156-60.

caused steep rise in violence against women which eventually led to reporting of riots in certain pockets of the country. In many places, military powers were used to ensure the proper implementation of the preventive measures.

It is apposite to note that the Britishers used the advent of the epidemic named bubonic plague to vilify Indians and to show them down. The Britishers initially attributed the advent of this epidemic in India to filthy and unsanitary living conditions, habits and local customs of Indians. A large portion of pandemic was attributable to mis-governance of public health system who attempted to strengthen their hold over society by enforcing whimsical health measures in the name of public safety.[6)]

It was the bubonic plague, caused by the rat flea, and manifesting itself in the form of buboes or swollen lymph nodes, nausea, and fever, that prompted the colonial government of the time to pass the Epidemic Diseases Act.[7)] When the situation started getting out of their hands, the Britishers hastily enacted the Epidemic Diseases Act, 1897 to deal with bubonic plague, a pandemic that claimed twelve million lives after its initial outbreak in Bombay Presidency in 1896[8)]. The Epidemic Diseases Act, 1897 had an authoritative connotation to it, since its inception. The undertone that public must trust the discretion of the government vesting of unbridled powers with local authorities affirmed was set. The Bill was passed amid concerns of the disease spreading from Bombay and was slowly reaching across all parts of India. Historian *David Arnold* called the Epidemic Diseases Act, 1897 as one of the most draconian pieces of sanitary legislation ever adopted in colonial India. The Epidemic Diseases Act, 1897 was a product of the colonizing efforts of the officials of Indian Medical Services, which gave them a freehand in exercising their whims and fancies[9)].

The Chairman of the Bombay Plague Committee, Brigadier General W.F. Gatacre along with P.C.H. Snow, the Municipal Commissioner of Bombay made a case for a strong law that cracked down on people who fled municipal limits. The Council member, J. Woodburn, tabled the Epidemic Diseases Bill on January 28,

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6) J. Ashburton Thompson*, Protection of India from invasion by bubonic plague*, Proceedings of the Royal Society of Medicine, Volume: 1 issue: Epidem_State_Med, May, 1908.

7) Deepak Kumar, *Disease & Medicine in India-A Historical Overview* (Reprint Edition), Tulika Books, ISBN 978-9382381051, 201.

8) Myron Echenberg, *Plague Ports: The Global Urban Impact Of Bubonic Plague,* NYU Press 1894-1901.

9) David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India*, 1st Edn., University of California Press Ltd.,1993.

1897, during an outbreak of bubonic plague. It led to the passage of the Epidemic Diseases Act, 1897.

The Bill was referred to a Select Committee headed by *James Westland*. The Committee submitted its report the very next week, on February 4, 1897, and the Bill was passed the same day, after a brief discussion. The Epidemic Diseases Act, 1897 is one of the shortest legislations in India, which originally comprised of just four sections.

The then President of Indian National Congress, Rahimtula Muhammad Sayani and Maharaja of Darbhanga, Lakshmishwar Singh accused that the Bill was passed in haste. The Bill called for special powers for governments of Indian provinces and local bodies, including to check passengers of trains and sea routes.

Quite similar to what the world is witnessing today-social distancing and quarantine in COVID times; emphasis was laid on isolation and outdoor quarantine camps even then during the times of bubonic plague. It is worthwhile to mention that the fundamentals to combat the pandemic remain the same even today.

The conditions that led to the implementation of the Epidemic Diseases Act, 1897 also saw the creation of an early infrastructure of medical surveillance, involving plague passports, exemption certificates, plague inoculation certificates and detentions. This infrastructure of medical surveillance was then extended to the presidencies and provinces such as Bengal, Madras, Delhi, Punjab, Central Provinces, and the city of Bangalore in Mysore Residency.

The powers conferred under the Epidemic Diseases Act, 1897 were invoked to search for suspected plague cases in homes and among passengers. There was forcible segregation of affected persons, disinfections, evacuation, and demolition of infected places. The assembly of crowds was prevented, public meetings and festivals were banned and pilgrimages suspended.

It is noteworthy that until COVID-19 had stricken India, the Epidemic Diseases Act, 1897 was invoked to fight dengue and malaria in cities like Chandigarh in 2015, cholera in Vadodara in 2018.When COVID-19 struck India, the central government announced its decision to invoke the Epidemic Diseases Act, 1897 at pan-India level.

Back then, the Epidemic Diseases Act, 1897 led to evolving of a system of railways surveillance in Bombay Presidency which entailed the creation of certificates of health that were attested to the health of all the passengers and railway staff while Bills of Health signed by the port Health Officers cleared passengers and crew from bubonic plague for travel on steamers. It is apposite to

note that in stressful COVID-19 times, we have witnessed the Maharashtra[10] government adopting the similar technique of stamping the left hand of the rising trend of fleeing suspects.

Offshoots of pandemic: social divide and caste system.

History asserts the fact that the effect of a pandemic are not restricted to its impact on normal human life and economy of a nation, but it has a deleterious effect even on social structure of the society at large. Pandemic had reflected signs of social divide in the past. For an instance, third class passengers were examined on the platform while second class passengers were examined in their carriages, and first class passengers were usually exempted altogether, during the days of bubonic plague. In fact, in central provinces, the Chief Commissioner issued orders to not detain all third class passengers, but only those regarded by reason of their appearance, by symptoms or dirty conditions of their clothes and effects. This reinforced the social divide which existed in India.

Even the caste system was not immune from the effect of a pandemic. Bubonic plague had its impact even on caste system. On April 6, 1897, Tilak's Marathi newspaper *Kesari* ran a story of a Brahmin who had to live on milk while in hospital because the food had been polluted by a Shudra's touch[11]. Similarly, there was a growing voice against closure of the Hindu plague hospital where caste observances were respected. Caste based hospitals were appreciated. As many as thirty (30) such hospitals were established by early 1898. Thus, the pandemic, in one sense, became a tool for Britishers to capitalize on their theory of divide and rule in India.

Plague in state of Baroda, Gujarat in 1898 and the years thereafter.

It would be correct to state that India had a troubled tryst with plague. Plague had ravaged India and had caused serious problems in India. Between 1898 and 1908, the annual mortality was over 5,00,000 deaths. The disease continued to be a major problem until mid-1940s.[12] In the state of Baroda, plague first appeared in Navsari and spread over the whole state with varying force by 1899. It occurred

10) Maharashtra is one of the states in India which was worst hit by COVID-19.

11) David Arnold, *Touching the Body: Perspectives on the Indian Plague 1896-1900,* Oxford University Press, 1988.

12) Dr. Richa Sharma, *Plague, Preventive Measures and Popular Unrest in the Baroda State*, Research Matrix International Multidisciplinary Journal of Applied Research Journal, Volume XXI, Issue 7, 2016.

again in 1924 and later in 1927-28.[13)]

Several measures were adopted by the state, including house to house inspection, inoculation and rigorous inspection of railways travellers etc. The Gaikwad Government by an order dated April 8, 1897 for the effectual carrying out of preventive measures, ordered the formation of Committee for the Baroda city and suburbs. The town was divided into twenty-two (22) circles and committee was formed in each circle to undertake house to house inspection for the detection of plague cases and to assist Government officers in removing persons whose removal was considered necessary to prevent the spread of plague infection to plague hospitals or segregation camps.[14)]

In the year 1917-18, the epidemic of plague gathered a very severe form, both in the districts and in the city of Baroda state. The epidemic reached its peak in Baroda during the months of December, 1917 and January, 1918 with a daily average of about 30 attacks and 25 deaths.[15)]

Sanction was accorded to engage sub-assistant surgeons in the temporary employment on plague war. One medical officer and four sub-assistant surgeons were placed at the disposal of the municipality for plague relief work.[16)]

On a comparative analysis of inoculations with bubonic plague of 1897, this time, because of past experience, people came forward more readily for inoculation, both in the city of Baroda and in the districts. Later, in subsequent years, the situation improved commendably as no plague was reported.

Another pandemic, Spanish flu, hit India in 1918 and impacted Indian politics during British colonial rule.

Spanish flu was the outbreak of deadly influenza. The killer fever, popularly known as the Spanish Flu, arrived from the sea in May-June of 1918 in Bombay.[17)] Over the next few months, the epidemic spread to other cities through railways. When the pandemic struck India, it became clear that British did not learn lessons from the bubonic plague and did not prioritize healthcare in India. Spanish flu killed almost 18 million in India. It claimed more lives than World War I, which

13) Dr. Richa Sharma, *Ph.D. thesis on Disease, Medicine and Health System in the Baroda State (1850 to 1947)*, M.S. University, Vadodara, 2010.
14) *Ibid.*
15) *Ibid.*
16) *Ibid.*
17) Lalit Kant & Randeep Guleria, *Pandemic Flu, 1918: After hundred years, India is as vulnerable*, Indian Journal of Medical Research, Vol. 147, Issue 3, 2018, pp. 221-224.

ended the same year when the pandemic had struck.

In terms of severity, Bombay, the Central Provinces, and parts of Madras were hardest hit. The districts with highest velocity, or lowest mean time to mortality, appear to be concentrated in Bombay, the Central Provinces, and Punjab as are the shortest duration districts. The earliest midpoint districts, likewise, are concentrated in Bombay, the Central Provinces, and parts of Madras and Punjab[18].

The disease was also oddly more widespread in the summer, whereas influenza cases usually spike in the winter. In India, the disease didn't affect the British and the privileged much, as they lived in large homes with ample space. But among the rest of the country, there was devastation. Because of shortage of wood for cremation, rivers and drains were filled with bodies[19].

The consequent toll of death and misery and economic fallout brought about by the pandemic led to an increase in emotion against colonial rule amongst Indians. It is worthwhile to mention that the pandemic was instrumental in uniting people against the British. Besides several other factors which had caused distrust and agony against British rule in India, the apathy which Britishers reflected in fighting Spanish flu spurred Indians to unite against Britishers and fight towards ending the British rule in India.

Legislations at state level that existed prior to COVID-19.

Public health falls under state list in India, which implies that states are empowered to enact laws on matters concerning public health. Quite a few states of India enacted certain state legislations relating to public health. The Madras Public Health Act, 1939 was the first of its kind in the country which was applicable in the state of Madras (now state of Tamil Nadu). Section 81 of the Madras Public Health Act, 1939 empowers the government to make such rules as they deem fit for the treatment of persons affected with any epidemic and for preventing the spread of the same. There are instances in which different parts of a state are following two different public health acts. For example, the southern districts of Kerala follow the Travancore- Cochin Public Health Act, 1955, while the northern districts follow the Madras Public Health Act, 1939 (made applicable to Malabar region in Kerala).

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18) Available at https: //indianhistorycollective. com/what-happened-to-the-virus-that-caused-the-worlds-deadliest-pandemic/ as last accessed on November 5, 2020.

19) Available at https: //theprint. in/health/this-is-what-1918-spanish-flu-can-teach-india-on-how-to-tackle-possible-second-covid-wave/415400/ as last accessed on November 6, 2020.

Section 86 of the Travancore Cochin Public Health Act, 1955 empowers the government to make rules as they deem fit for the treatment of persons affected with any epidemic, endemic or even infectious disease. The Goa, Daman and Diu Public Health Act was also enacted in 1985 on similar lines.

It is however pertinent to observe that in fight against COVID-19, none of the state legislations were extensively used to curb spread of virus amongst citizens. Instead the major reliance was only on the provisions of the Epidemic Diseases Act, 1897 to combat COVID-19.

An overview of the Public Health (Prevention, Control and Management of Epidemics, Bio-Terrorism And Disasters) Bill, 2017(The "2017 Bill")-

Before India plunged into the worst health crisis ever, there were some efforts made to promulgate the 2017 Bill which would have repealed the century-old legislation i.e., the Epidemics Diseases Act, 1897 and would have made the regulatory regime more in consonance with the present times. The 2017 Bill could not see the light of the day and possibly, had the 2017 Bill been in force, India would have fought COVID-19 in a more structured and robust manner. The National Centre for Disease Control (NCDC) and the Directorate General of Health Services (DGHS) jointly prepared the 2017 Bill citing the need to empower government bodies during health emergencies.

The 2017 Bill aimed to address health emergencies that India may face in the future besides repealing the Epidemic Diseases Act, 1897. Concerns about the sudden focus on bioterrorism and lack of governmental enthusiasm on the subject ensured that the Bill was never tabled in the Parliament. Certain provisions of the 2017 quite noteworthy and in hindsight, it appears that had the 2017 Bill been in force, India would have differently fought the COVID-19.

The terms viz. "epidemic"[20], "isolation"[21], "quarantine"[22] and "social

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20) Epidemic has been defined in clause 2(m) of the 2017 Bill as:
"epidemic" means the occurrence in a community or region of cases of an illness, specific health related behavior, or other health related events clearly in excess of normal expectancy.

21) Isolation has been defined in clause (p) of the 2017 Bill as:
"isolation" means separation of ill or contaminated persons or affected baggage, containers, conveyances, goods or postal parcels from others in such a manner as to prevent the spread of infection or contamination.

22) Quarantine has been defined in clause 2(dd) of the 2017 Bill as:
"quarantine" means the restriction of activities and/or separation from others of suspect ↗

distancing"[23] were used in the 2017 Bill and the 2017 Bill had clear definitions for public health emergency of international concern, ground crossing, disinfection, de-ratting, decontamination. The sad and uninviting part is that the 2017 Bill could not gather support as concerns were raised over the sweeping powers were granted to the states to subject a person to compulsory treatment, even without consent.

It is necessary to peruse some of the pertinent provisions of the 2017 Bill. Clause 2 (d) of the 2017 Bill provided the definition of the term "clinical establishment"[24] and gave a wide amplitude to the term. Every medical facility, irrespective of its size, ownership composition, and speciality, was brought under the scope of clinical establishment for the purposes of the 2017 Bill. The only exception carved out is relating to clinical establishments owned, managed and controlled by the armed forces.

Clause 3 of the 2017 Bill sets out the requirement of the wide connotation given to the term "clinical establishment". Clause 3 of the 2017 Bill conferred extraordinary powers to the state governments, union territories, district and local administrations. The afforested instrumentalities could mandate health measures,

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↘ persons who are not ill or of suspect baggage, containers, conveyances or goods in such a manner as to prevent the possible spread of infection or contamination.

23) Social distancing has been defined in clause 2(hh) of the 2017 Bill as:
"social distancing" is a public health practice designed to limit the spread of infection by ensuring sufficient physical distance between individuals.

24) "Clinical establishment" includes:
(i) a hospital, maternity home, nursing home, dispensary, clinic, sanatorium or an institution by whatever name called that offers services, facilities with beds requiring diagnosis, treatment or care for illness, injury, deformity, abnormality or pregnancy in any recognized system of medicine;
(ii) a place established as an independent entity or part of an establishment as defined in d (i) above in connection with the diagnosis or treatment of diseases where pathological, bacteriological, genetic, radiological, bio-chemical, biological investigations or other diagnostic or investigative services with the aid of laboratory or other medical equipments, are usually carried on, established and administered or maintained by any person or body of persons, whether incorporated or not, and shall include a clinical establishment owned, controlled or managed by
a) the Government or a department of the Government;
b) a trust, whether public or private;
c) a corporation (including a society) registered under a Central, Provincial or State Act, whether or not owned by the Government;
d) a local authority; and
e) a single doctor, but does not include the clinical establishments owned, controlled or managed by the Armed Forces.

including isolation, quarantine and social distancing to any person or class of persons. The said instrumentalities are empowered to prohibit certain activities, ban or regulate drugs and other hazardous substances, conduct medical tests, and undertake diverse decontamination measures. By way of Clause 3 of the 2017 Bill, the authorities had the competency to issue directives to all clinical establishments.

In consonance with the other emergency provisions, the 2017 Bill allowed the Central Government to disregard the unique federal structure of India if it appears that it would be expedient and in public interest to do so, and confer unto itself the powers that were prescribed in Clause 3 of the 2017 Bill.

It is worth noting that the federal structure of the nation had been allowed to be slightly disrupted under the 2017 Bill so as to align national action against pandemics, especially when ephemeral changes to health policies do not adversely affect the socio-legal outline of states. This is quite significant as the pandemics lead to extraordinary situations, which demand extraordinary measures to fight tooth and nail against a pandemic. Hence, in the interests of the nation, if federal structure of the nation has to be attenuated for certain period of time, it should be permitted and the 2017 Bill only reaffirmed the said precept.

Clause 7[25)] of the 2017 Bill would have turned out to be a strong deterrent in the present times when India is reeling from COVID-19. Clause 7 of the 2017 Bill allowed any person authorised by the Bill or the rules made thereunder within the definition of "public servant". This would have deterred those notorious and mischievous elements of society who resorted to violence against healthcare workers.

The 2017 Bill provided for sundry penalties for different situations. The penalty amounts provided for first contravention, repeat contravention, and wilful contravention and the positive side of it was that the amounts prescribed were attuned to present socio-economic conditions of Indians and would have certainly caused a deterrence.

The fourteen clauses (sections) in the 2017 Bill were supplemented by two schedules. The first schedule enlisted epidemic-prone diseases. The second schedule enlisted potential bio-terrorism agents. It is to be noted that the first schedule included SARS, of which the novel coronavirus (also known as SARS-COV-2) is a mutation.

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25) Certain Persons deemed to be public servants: Any person authorized to take any action under this Act or any Order or Rule made thereunder, shall be deemed to be a public servant within the meaning of section 21 of the Indian Penal Code.

Thus, had the 2017 Bill been in force, it would have been applicable without requiring any amendments to this schedule. The repercussions of the current chaotic situation reinforce the need of reintroduction of the 2017 Bill or the introduction of a similar legislation so that if at all, India faces another pandemic in times to come, we are better prepared to effectively deal with the same. While a journey into the history helps us in learning lessons, but history has to be fine-tuned with need of emerging times.

Conclusion

India has seen it all; be it a pandemic leading to caste divide and social divide and how a very small piece of legislation could be extensively used to combat a pandemic. The VII Schedule of the Constitution of India, 1950 enlists public health under state list. Therefore, a lot of discretion is with the state government to adopt, enact, and enforce public health related regulations. While it is true that India has met a pandemic after almost a century and the experience learnt from the previous pandemics had faded away in these many years, however, certain significant core lessons learnt historically; be it isolations, stamping and quarantines have continued to stay even today[26]. As the society grew, the need for amending the Epidemic Diseases Act, 1897 did not arise as India did not face any pandemic which had such widespread repercussions in these many years. But, when COVID-19 struck India, the Epidemic Diseases Act, 1897 was significantly amended as that was the only legislation in place in India to combat a pandemic. While the Central Government (Government of India) invoked provisions of the Disaster Management Act, 2005 to combat the infection by introducing lockdowns to keep the growing rate of infections under check, however, it is equally true that the Disaster Management Act, 2005, in true sense, is not a legislation enacted to fight a pandemic. The objectives and preamble of the Disaster Management Act, 2005 affirm this understanding.

Although the Epidemic Diseases Act, 1897 appears quite regulatory in nature; it does not address the multi-faceted dimensions of public health issues of India[27]. For an instance, whilst the Epidemic Diseases Act, 1897 harps on action by governments, it does not cast a duty on the government to ensure supply of

26) Stanley M. Lemon, Margaret A. Hamburg, P. Frederick Sparling, Eileen R. Choffnes, and Alison Mack, *Ethical and legal considerations in mitigating pandemic diseases: Workshop Summary*, National Academies Press (US), 2007.

27) Manish Tewari, *India's Fight Against Health Emergencies: In Search of a Legal Architecture*, Observer Research Foundation, Issue Brief No. 349, March 2020.

essential commodities to the destitutes. Similarly, the Epidemic Diseases Act, 1897 harps on travel by sea and rightly so, as air travel was uncommon at the time when legislation was introduced. Thus, it would not be incorrect to state that India's existing laws fall short of meeting the challenges of a pandemic. It is apposite to note that in 1955 and later in 1987, the Government had drafted the Public Health Act, but states did not support the same. Again in 2009, the National Health Bill, 2009 aimed to establish a comprehensive legal structure by including essential public safety programmes and obligations in public health emergency through the successful collaboration between the centre and the states, but again the bill could not become the law. It is further worthwhile to mention that the 2017 Bill[28], which proposed to repeal the Epidemic Diseases Act, 1897, was clearer with regard to isolation of infected and quarantining of suspects in addition to empowering the Centre to direct states and district or local bodies as well as usurping powers bestowed to states if it was found to be expedient and in public interests to do so. The Bill also had clear definitions for the terms like epidemic, isolation, quarantine, social distancing, public health emergency, public health emergency of international concern, ground crossing, disinfection, disinfection, and decontamination etc. Unfortunately, the 2017 Bill could not see the light of the day. The need of the hour is to resurrect and resuscitate the bill and bring it into force after duly incorporating the effective responses to bitter lessons that have been learnt from the horrifying experiences of COVID-19 and in fact, while incorporating effective responses into the legislation, not only position in India must be considered but all lessons learnt by sundry nations should be considered and brought together in form of a legislation/law.

While India requires a new legislation to fight a pandemic as the century-old legislation had its own pitfalls, but certain important lessons could be learnt from historical trysts with pandemics. With the ever-evolving and progressive era of globalization, India needs to appreciate that good health a basic right of an individual and tracing back the history, it is unequivocally clear that nothing is new under the sky, when we even talk of COVID-19[29]. Age-old isolation and quarantine measures have actually proven beneficial to contain the growing spread

28) Available at https://www.prsindia.org/uploads/media/draft/Draft%20PHPCM%20of%20Epidemics,%20Bio-Terrorism%20and%20Disasters%20Bill,%202017. pdf as last accessed on October 26, 2020.

29) T. Dikid, *Emerging and re-emerging infections in India: overview*. Indian Journal of Medical Research, 2013, pp. 19-31.

of COVID-19. Additionally, it is equally true that India requires more grants to develop new vaccines and preventive and curative medicines. Possibly and hopefully, with the hard lessons learnt from the experience of COVID-19 in this century, the governments would realize the importance of a robust health policy and health related laws and India would have its new law to sturdily fight epidemics soon. If someone were to enunciate a positive outcome of COVID-19, it would certainly be that COVID-19 has provided a remarkable opportunity to the government to fine-tune its laws with the present times and to update and upgrade its health laws across the length and breadth of the nation.